

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33193

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1816

1. PLACE OF DEATH:

(a) County St Louis **FILED OCT 23 1946**
(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6416 Spencer Place
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Josephine Kaiser

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emil Kaiser 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased April 12 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 5 12 _____ hr. _____ min.

9. Birthplace Des Peres Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name Jacob Schillinger
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Katharine Bautz
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Emil Kaiser
(b) Address 6416 Spencer Place

17. (a) Burial (b) Date thereof Sept 27 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hiram Park Cem

18. (a) Signature of funeral director Beiderwieden Funl Home Inc
(b) Address 1936 St Louis NBE

19. (a) SEP 25 1946 (b) R. M. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City Wellston
(If outside city or town limits, write "RURAL")
(d) Street No. 6416 Spencer Place
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 24
year 1946 hour 9:32 minute A M.

21. I hereby certify that I attended the deceased from Sept 17
1946 to Sept 24 1946;
that I last saw her alive on Sept 14 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Central Hemorrhage

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations g. g. g.
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Edw. L. Eason (M. D. or other) 1
Address 6012 Barton av Date signed 9/25/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MI 29700
6012 B. B. B. B. B.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____ *Max Warfel* _____, Registered Apprentice No. 215
working under my personal supervision.

Signed *Felix J. Krissin* _____

Licensed Embalmer No. 3497

P. O. Address 1936 St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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